		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041723

Facility Name: PROVENA OUR LADY OF VICTORY

Address: 20 BRIARCLIFF LANE (Number) BOURBONNAIS (City) 60914 (Zip Code)

County: KANKAKEE

Telephone Number: (815) 937-2022 **Fax #** (815) 936-3231

IDPA ID Number: 371127787009

Date of Initial License for Current Owners: 11/6/81

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501 (C3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Lynda Olinski **Telephone Number:** (708) 478-7916

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Michael R. Gordon
(Title) VP of Finance, CFO

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number PROVENA OUR LADY OF VICTORY # 0041723 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	55	Skilled (SNF)	55	20,130	1
2		Skilled Pediatric (SNF/PED)			2
3	52	Intermediate (ICF)	52	19,032	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	107	TOTALS	107	39,162	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	13,427		3,443	16,870	8
9	SNF/PED					9
10	ICF	13,427	4,405		17,832	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,854	4,405	3,443	34,702	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.61%

D. How many bed-hold days during this year were paid by Public Aid?
79 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A - None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/16/1981

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/16/1981 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 28 and days of care provided 3,443

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number PROVENA OUR LADY OF VICTORY # 0041723 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	184,579	15,555	14,148	214,282		214,282		214,282			1
2	Food Purchase		172,106		172,106		172,106	1,071	173,177			2
3	Housekeeping	115,164	21,943	(525)	136,582		136,582		136,582			3
4	Laundry	34,482	2,868		37,350		37,350		37,350			4
5	Heat and Other Utilities			121,329	121,329		121,329	543	121,872			5
6	Maintenance	59,682	2,355	34,690	96,727		96,727	26,684	123,411			6
7	Other (specify):* Pastoral Care/Develop	44,123	393	50,627	95,143		95,143	(48,297)	46,846			7
8	**TOTAL General Services**	438,030	215,220	220,269	873,519		873,519	(19,999)	853,520			8
	B. Health Care and Programs											
9	Medical Director			8,548	8,548		8,548		8,548			9
10	Nursing and Medical Records	1,505,874	104,960	238,984	1,849,818		1,849,818		1,849,818			10
10a	Therapy			158,162	158,162		158,162		158,162			10a
11	Activities	58,017	175	2,369	60,561		60,561	954	61,515			11
12	Social Services	25,393		456	25,849		25,849		25,849			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,589,284	105,135	408,519	2,102,938		2,102,938	954	2,103,892			16
	C. General Administration											
17	Administrative	187,078	3,344	361,096	551,518		551,518	(176,613)	374,905			17
18	Directors Fees											18
19	Professional Services			32,347	32,347		32,347	186,487	218,834			19
20	Dues, Fees, Subscriptions & Promotions			27,040	27,040		27,040	1,548	28,588			20
21	Clerical & General Office Expenses		12,064	5,957	18,021		18,021	(4,690)	13,331			21
22	Employee Benefits & Payroll Taxes			533,446	533,446		533,446	57,153	590,599			22
23	Inservice Training & Education			9,801	9,801		9,801	3,585	13,386			23
24	Travel and Seminar			7,770	7,770		7,770	3,157	10,927			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			40,144	40,144		40,144	3,528	43,672			26
27	Other (specify):* Bad Debt			125,668	125,668		125,668	(99,511)	26,157			27
28	**TOTAL General Administration**	187,078	15,408	1,143,269	1,345,755		1,345,755	(25,356)	1,320,399			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,214,392	335,763	1,772,057	4,322,212		4,322,212	(44,401)	4,277,811			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number PROVENA OUR LADY OF VICTORY #0041723 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			226,559	226,559		226,559	74,321	300,880			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							85,876	85,876			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			3,118	3,118		3,118	6,953	10,071			34
35	Rent-Equipment & Vehicles			41,809	41,809		41,809	704	42,513			35
36	Other (specify):* Loss on Asset Disposals			100	100		100		100			36
37	**TOTAL Ownership**			271,586	271,586		271,586	167,854	439,440			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			173,680	173,680		173,680		173,680			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			58,743	58,743		58,743		58,743			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			232,423	232,423		232,423		232,423			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,214,392	335,763	2,276,066	4,826,221		4,826,221	123,453	4,949,674			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number PROVENA OUR LADY OF VICTORY # 0041723 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	14,696	30		9
10	Interest and Other Investment Income	(3,727)	22		10
11	Discounts, Allowances, Rebates & Refunds	(9,478)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(125,668)	27		24
25	Fund Raising, Advertising and Promotional	(7,392)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (131,569)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	304,323		34
35	Other- Attach Schedule	(49,301)		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 255,022		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 123,453		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

PROVENA OUR LADY OF VICTORY

ID# 0041723

Report Period Beginning: 01/01/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Development Salares	$ (15,210)	7	1
2	Development Activities/Fundraising			2
3	Development Miscellaneous	(33,087)	7	3
4	Development Benefits	(1,004)	22	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(49,301)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PROVENA OUR LADY OF VICTORY # 0041723 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	1,071	0	0	0	0	0	0	0	0	0	1,071	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	543	0	0	0	0	0	0	0	0	0	543	5
6	Maintenance	0	194	26,490	0	0	0	0	0	0	0	0	26,684	6
7	Other (specify):*	(48,297)	0	0	0	0	0	0	0	0	0	0	(48,297)	7
8	**TOTAL General Services**	(48,297)	1,808	26,490	0	0	0	0	0	0	0	0	(19,999)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	954	0	0	0	0	0	0	0	0	0	954	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	954	0	0	0	0	0	0	0	0	0	954	16
	C. General Administration													
17	Administrative	0	(152,876)	(23,737)	0	0	0	0	0	0	0	0	(176,613)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	14,549	171,938	0	0	0	0	0	0	0	0	186,487	19
20	Fees, Subscriptions & Promotions	(7,392)	8,940	0	0	0	0	0	0	0	0	0	1,548	20
21	Clerical & General Office Expenses	(9,478)	4,788	0	0	0	0	0	0	0	0	0	(4,690)	21
22	Employee Benefits & Payroll Taxes	(4,731)	23,161	38,723	0	0	0	0	0	0	0	0	57,153	22
23	Inservice Training & Education	0	3,585	0	0	0	0	0	0	0	0	0	3,585	23
24	Travel and Seminar	0	3,157	0	0	0	0	0	0	0	0	0	3,157	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	3,528	0	0	0	0	0	0	0	0	0	3,528	26
27	Other (specify):*	(125,668)	0	26,157	0	0	0	0	0	0	0	0	(99,511)	27
28	**TOTAL General Administration**	(147,269)	(91,168)	213,081	0	0	0	0	0	0	0	0	(25,356)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(195,566)	(88,406)	239,571	0	0	0	0	0	0	0	0	(44,401)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number PROVENA OUR LADY OF VICTORY # 0041723 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	14,696	0	59,625	0	0	0	0	0	0	0	0	74,321	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	85,876	0	0	0	0	0	0	0	0	85,876	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	6,953	0	0	0	0	0	0	0	0	6,953	34
35	Rent-Equipment & Vehicles	0	0	704	0	0	0	0	0	0	0	0	704	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	14,696	0	153,158	0	0	0	0	0	0	0	0	167,854	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(180,870)	(88,406)	392,729	0	0	0	0	0	0	0	0	123,453	45

Facility Name & ID Number PROVENA OUR LADY OF VICTORY # 0041723 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	2	Food	$	Provena Senior Services	100.00%	$ 1,071	$ 1,071	1
2	V	5	Utilities		Provena Senior Services	100.00%	543	543	2
3	V	6	Maintenance - Other		Provena Senior Services	100.00%	194	194	3
4	V	11	Activities-Special Events		Provena Senior Services	100.00%	954	954	4
5	V	17	Admin - Misc. Other	230,596	Provena Senior Services	100.00%	2,266	(228,330)	5
6	V	17	Administrative Salaries		Provena Senior Services	100.00%	75,454	75,454	6
7	V	19	Professional Services		Provena Senior Services	100.00%	14,549	14,549	7
8	V	20	Dues,Subscriptions		Provena Senior Services	100.00%	8,940	8,940	8
9	V	21	Clerical Supplies		Provena Senior Services	100.00%	4,788	4,788	9
10	V	22	Employee Benefits		Provena Senior Services	100.00%	23,161	23,161	10
11	V	23	Education/Conference		Provena Senior Services	100.00%	3,585	3,585	11
12	V	24	Travel		Provena Senior Services	100.00%	3,157	3,157	12
13	V	26	Insurance		Provena Senior Services	100.00%	3,528	3,528	13
14	Total			$ 230,596			$ 142,190	$ * (88,406)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PROVENA OUR LADY OF VICTORY # 0041723 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	27	Bad Debt	$	Provena Senior Services	100.00%	$ 26,157	$ 26,157	15
16	V	30	Depreciation		Provena Senior Services	100.00%	1,425	1,425	16
17	V	32	Interest		Provena Senior Services	100.00%	85,876	85,876	17
18	V	34	Rent - Facility		Provena Senior Services	100.00%	6,953	6,953	18
19	V	35	Rent - Equipment		Provena Senior Services	100.00%	704	704	19
20	V	17	Admin Salaries	77,184	Provena Health Services	100.00%	50,027	(27,157)	20
21	V	22	Employee Benefits		Provena Health Services	100.00%	18,124	18,124	21
22	V	30	Depreciation		Provena Health Services	100.00%	58,200	58,200	22
23	V	19	Admin Consulting,Other		Provena Health Services	100.00%	171,938	171,938	23
24	V	17	Information Systems Salaries	53,316	Provena Health Services	100.00%	10,239	(43,077)	24
25	V	22	Information Systems Benefits		Provena Health Services	100.00%	3,754	3,754	25
26	V	6	Information Systems - Equip Maint		Provena Health Services	100.00%	5,014	5,014	26
27	V	17	Admin Salaries		Provena Health Services	100.00%	30,319	30,319	27
28	V	22	Employee Benefits		Provena Health Services	100.00%	10,984	10,984	28
29	V	17	Information Systems Salaries		Provena Health Services	100.00%	16,178	16,178	29
30	V	22	Information Systems Benefits		Provena Health Services	100.00%	5,861	5,861	30
31	V	6	Information Systems - Equip Maint		Provena Health Services	100.00%	21,476	21,476	31
32	V	39	Ancillary Services - Other	173,680	Provena Senior Services Pharmacy	100.00%	173,680		32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 304,180			$ 696,909	$ * 392,729	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PROVENA OUR LADY OF VICTORY # 0041723 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number PROVENA OUR LADY OF VICTORY # 0041723 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Provena Senior Services
Street Address: 19065 Hickory Creek Drive, Ste 310
City / State / Zip Code: Mokena, IL60448
Phone Number: (708)478-7900
Fax Number: (708)478-5387

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Management Fee Income	4,942,944	16	$ 22,950	$	230,596	$ 1,071	1
2	5	Utilities	Management Fee Income	4,942,944	16	11,646		230,596	543	2
3	6	Maintenance - Other	Management Fee Income	4,942,944	16	4,154		230,596	194	3
4	11	Activities-Special Events	Management Fee Income	4,942,944	16	20,442		230,596	954	4
5	17	Admin - Misc. Other	Management Fee Income	4,942,944	16	48,582		230,596	2,266	5
6	17	Administrative Salaries	Management Fee Income	4,942,944	16	1,617,398	1,617,398	230,596	75,454	6
7	19	Professional Services	Management Fee Income	4,942,944	16	311,867		230,596	14,549	7
8	20	Dues,Subscriptions	Management Fee Income	4,942,944	16	191,638		230,596	8,940	8
9	21	Clerical Supplies	Management Fee Income	4,942,944	16	102,640		230,596	4,788	9
10	22	Employee Benefits	Management Fee Income	4,942,944	16	496,473		230,596	23,161	10
11	23	Education/Conference	Management Fee Income	4,942,944	16	76,847		230,596	3,585	11
12	24	Travel	Management Fee Income	4,942,944	16	67,676		230,596	3,157	12
13	26	Insurance	Management Fee Income	4,942,944	16	75,628		230,596	3,528	13
14	27	Bad Debt	Management Fee Income	4,942,944	16	560,691		230,596	26,157	14
15	30	Depreciation	Management Fee Income	4,942,944	16	30,542		230,596	1,425	15
16	32	Interest	Management Fee Income	4,942,944	16	1,840,794		230,596	85,876	16
17	34	Rent - Facility	Management Fee Income	4,942,944	16	149,043		230,596	6,953	17
18	35	Rent - Equipment	Management Fee Income	4,942,944	16	15,101		230,596	704	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,644,112	$ 1,617,398		$ 263,305	25

Facility Name & ID Number PROVENA OUR LADY OF VICTORY # 0041723 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Provena Health Services
Street Address: 9223 West St. Francis Road
City / State / Zip Code: Frankfort, IL 60423
Phone Number: (815)469-4888
Fax Number: (815)469-4864

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Admin Salaries	Operating Expense	1,101,876		$ 714,188	$ 714,188	77,184	$ 50,027	1
2	22	Employee Benefits	Operating Expense	1,101,876		258,738		77,184	18,124	2
3	30	Depreciation	Operating Expense	1,101,876		830,857		77,184	58,200	3
4	19	Admin Consulting,Other	Operating Expense	1,101,876		2,454,578		77,184	171,938	4
5	17	Information Systems Salaries	Operating Expense	761,172		146,180	146,180	53,316	10,239	5
6	22	Information Systems Benefits	Operating Expense	761,172		53,593		53,316	3,754	6
7	6	Information Systems - Equip Mai	Operating Expense	761,172		71,577		53,316	5,014	7
8	17	Admin Salaries	Direct Cost	1,101,876		432,829	432,829	77,184	30,319	8
9	22	Employee Benefits	Direct Cost	1,101,876		156,806		77,184	10,984	9
10	17	Information Systems Salaries	Direct Cost	761,172		230,974	230,974	53,316	16,178	10
11	22	Information Systems Benefits	Direct Cost	761,172		83,678		53,316	5,861	11
12	6	Information Systems - Equip Mai	Direct Cost	761,172		306,605		53,316	21,476	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,740,603	$ 1,524,171		$ 402,114	25

Facility Name & ID Number PROVENA OUR LADY OF VICTORY # 0041723 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Provena Senior Services Pharmacy
Street Address: 1475 Harvard Drive
City / State / Zip Code: Kankakee, IL 60901
Phone Number: (815)928-6141
Fax Number: (815)946-3238

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Ancillary Services - Other	Direct Cost			$	$		$ 173,680	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 173,680	25

Facility Name & ID Number PROVENA OUR LADY OF VICTORY # 0041723 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	Provena Senior Services										85,876	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 85,876	14
15	TOTALS (line 9+line14)						$	$			$ 85,876	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number PROVENA OUR LADY OF VICTORY # 0041723 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1999	8
	2000	9
	2001	10
	2002	11
	2003	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PROVENA OUR LADY OF VICTORY COUNTY KANKAKEE

FACILITY IDPH LICENSE NUMBER 0041723

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number PROVENA OUR LADY OF VICTORY # 0041723 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,172 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home		1981	$ 135,000	1
2	Related Party		1985	3,003	2
3	TOTALS			$ 138,003	3

Facility Name & ID Number PROVENA OUR LADY OF VICTORY # 0041723 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	80			1981	$ 507,112	$ 20,284	25	$ 20,284	$	$ 469,916	4
5	8			1984	726,964	29,079	25	29,079		610,215	5
6	9			1987	63,355	1,496	20	1,496		58,967	6
7	10			1995	2,520,706	64,282	35	64,282		601,060	7
8											8
	Improvement Type**										
9	DESC: ADDITIONAL SMOKE DETECTORS			2004	3,649	365	10	365	(0)	365	9
10	DESC: EMERGENCY GENERATOR			2004	5,363	536	5	1,073	536	1,073	10
11	DESC: SPRINKLER			2004	2,126	43	25	85	43	85	11
12	DESC: DESIGN FOR SPRINKLER PROJECT			2004	90	2	20	5	2	5	12
13	DESC: IDPH FINAL PUNCH LIST ITEMS			2004	1,538	51	15	103	51	103	13
14	DESC: CONNECT BATHROOM EXHAUST FANS, CIRCU			2004	1,989	199	5	398	199	398	14
15	DESC: DESIGN FOR SPRINKLER SYSTEM PHASE 3			2004	90	9	5	18	9	18	15
16	DESC: COOLING UNIT FOR FRONT LOBBY			2004	12,900	645	10	1,290	645	1,290	16
17	DESC: B & F REVIEW FOR SPRINKLER			2004	462	46	5	92	46	92	17
18	DESC: CONSTRUCTION ADMIN - OLOV SPRINKLER			2004	45	5	5	9	5	9	18
19	DESC: EXTERIOR PAINTING			2004	2,825	283	5	565	283	565	19
20	DESC: SPRINKLER SYSTEM			2004	40,020	800	25	1,601	800	1,601	20
21	DESC: SPRINKLER SYSTEM PHASE 3 AND 4			2004	135	14	5	27	14	27	21
22	DESC: PAINTING WORK FOR SPRINKLER PROJECT			2004	3,631	363	5	726	363	726	22
23	DESC: SPRINKLER SYSTEM PHASE 3 AND 4			2004	585	59	5	117	59	117	23
24	DESC: REMOVE / REPLACE EXHAUST FANS			2004	14,741	491	15	983	491	983	24
25	DESC: ELECTRICAL INSTALLATION FOR BATHROOM			2004	2,255	113	10	226	113	226	25
26	DESC: FLEXIBLE DUCT REPLACEMENT			2004	2,366	118	10	237	118	237	26
27	DESC: RELOCATE 2 PULL FIRE ALARMS, INSTALL			2004	3,942	394	5	788	394	788	27
28	DESC: REMODEL BATHROOMS			2004	34,166	1,139	15	2,278	1,139	2,278	28
29	DESC: MOVED DRY PENDENT IN VESTIBULE AND A			2004	1,632	82	10	163	82	163	29
30	DESC: 2 DRY SPRINKLERS IN ELECTRICAL ROOM			2004	1,363	68	10	136	68	136	30
31	DESC: AWNING FOR TLC ENTRANCE			2004	4,300	143	15	287	143	287	31
32	DESC: VINYL GRAPHICS TO 2 AWNINGS			2004	380	19	10	38	19	38	32
33	DESC: GENERATOR INSPECTION & REPAIR			2004	1,534	153	5	307	153	307	33
34	DESC: BATHROOM RENOVATION			2004	80,548	2,685	15	5,370	2,685	5,370	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number PROVENA OUR LADY OF VICTORY # 0041723 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	DESC: OLV CONVERSION / ARCHITECTURAL SERVI	2003	$ 1,575	$ 315	5	$ 315	$	$ 473	37
38	DESC: LIFE SAFTEY CODE CERTIFICATION	2003	90	18	5	18		27	38
39	DESC: NINE NEW SMOKE DETECTORS	2003	5,734	573	10	573		860	39
40	DESC: CARPET FOR LOBBY	2003	1,063	213	5	213		319	40
41	DESC: CONSTRUCTION ADMINISTRATION-SPRINKLE	2003	315	63	5	63		95	41
42	DESC: CEILING REPAIR	2003	2,041	204	10	204		306	42
43	DESC: REGRADE/RESOIL EMPLOYEE PARKING LOT	2003	7,197	720	10	720		1,080	43
44	DESC: CARPET FOR A WING	2003	4,710	942	5	942		1,884	44
45	DESC: FIRE PROTECTION SYSTEM	2003	79,026	7,903	10	7,903		7,903	45
46	DESC: SPRINKLER SYSTEM	2003	32,123	1,285	25	1,285		1,285	46
47	DESC: HEATING AND COOLING HVAC UNITS	2003	42,000	2,800	15	2,800		2,800	47
48									48
49	DESC: PAINTING, PATCHING AND SANDING	2002	4,733	947	5	947		2,367	49
50	DESC: 80 GAL HOT WATER HEATER	2002	2,301	230	10	230		575	50
51	DESC: ELECTRIC HEATING AND COLLOING UNITS	2002	3,990	266	15	266		665	51
52	DESC: REPAIR BROKEN PIPE IN ATTIC	2002	119	12	10	12		24	52
53	DESC: REPAIR CONDUIT AND WIRES IN ATTIC	2002	108	11	10	11		22	53
54	DESC: GARBAGE DISPOSAL	2002	616	123	5	123		308	54
55	DESC: IDPA LICENSING	2002	450	90	5	90		225	55
56	DESC: IDPA LICENSING	2002	4,631	926	5	926		2,315	56
57	DESC: A/C PACKAGE HEAT PUMP	2002			10			87	57
58	DESC: A/C PACKAGE HEAT PUMP	2002	865	87	10	87		173	58
59	DESC: LIFE SAFETY CODE CERTIFICATION	2002	11,545	1,649	7	1,649		3,299	59
60	DESC: SPRINKLER SYSTEM PHASE TWO	2002	38,439	3,844	10	3,844		7,688	60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,284,484	$ 147,186		$ 155,646	$ 8,460	$ 1,792,219	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PROVENA OUR LADY OF VICTORY # 0041723 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,284,484	$ 147,186		$ 155,646	$ 8,460	$ 1,792,219	1
2	DESC: NATURAL GAS WATER HEATER - A O SMITH	2001	3,225	806	4	806		2,822	2
3	DESC: LAUNDRY ROOM SINK	2001	6,500	1,300	5	1,300		4,550	3
4	DESC: RGB MAJOR BUILDING CONSULTING	2001	495	99	5	99		347	4
5	DESC: AIR COMPRESSOR & SPRINKLER REPAIRS	2001	1,868	374	5	374		1,307	5
6	DESC: WATER HEATER (A O SMITH)	2001	3,810	381	10	381		1,334	6
7	DESC: WATER SERVICE	2001	7,950	1,590	5	1,590		5,565	7
8	DESC: REPLACE RESIDENT ROOM "THROUGH WALL"	2001	1,335	134	10	134		467	8
9	DESC: SPRINKLER REPLACEMENT	2001	662	132	5	132		463	9
10	DESC: SPRINKLER SYSTEM	2001	4,904	981	5	981		3,433	10
11	DESC: SPRINKLER SYSTEM	2001	76,441	7,644	10	7,644		26,754	11
12									12
13	VARIOUS	2000	24,736	3,473	7	3,473		15,630	13
14	VARIOUS	1999	74,075	5,100	6	5,100		48,375	14
15	VARIOUS	1998	48,287	1,707	5	1,707		47,434	15
16	VARIOUS	1997	104,421	1,966	5	1,966		99,507	16
17	VARIOUS	1996	192,299	10,905	11	10,905		91,829	17
18	VARIOUS	1995	9,836	138	6	138		9,767	18
19	VARIOUS	1994	3,258	60	8	60		3,258	19
20	VARIOUS	1992	12,150	608	20	608		7,290	20
21	VARIOUS	1991	21,073		10			21,073	21
22	VARIOUS	1990	90,796	6,053	15	6,053		87,769	22
23	VARIOUS	1989	1,046	105	15	105		1,046	23
24	VARIOUS	1988	6,000		15			6,000	24
25	VARIOUS	1987	13,473	642	21	642		11,226	25
26	VARIOUS	1986	17,173	818	21	818		14,313	26
27	VARIOUS	1982	300		15			300	27
28	VARIOUS	1982	95,473	3,819	25	3,819		9,546	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,106,071	$ 196,020		$ 204,480	$ 8,460	$ 2,313,623	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PROVENA OUR LADY OF VICTORY # 0041723 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 210,349	$ 18,688	$ 18,688	$	7	$ 153,679	71
72	Current Year Purchases	105,951	6,237	12,474	6,237	9	12,474	72
73	Fully Depreciated Assets	187,056					187,056	73
74	Home Office Allocation			59,625	59,625			74
75	TOTALS	$ 503,357	$ 24,925	$ 90,787	$ 65,862		$ 353,209	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1999 FORD ELDORADO	1999	$ 44,910	$ 5,614	$ 5,614	$	6	$ 30,876	76
77										77
78										78
79										79
80	TOTALS			$ 44,910	$ 5,614	$ 5,614	$		$ 30,876	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,792,340	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 226,559	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 300,880	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 74,322	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,697,708	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ 3,118			3
4	Additions							4
5	Allocation Home Office				6,953			5
6								6
7	TOTAL				$ 10,071 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: [ ] YES [x] NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO

16. Rental Amount for movable equipment: $ 42,513 Description: Nursing - $40,408.24, Admin - $1401, Home Office - $704
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number PROVENA OUR LADY OF VICTORY # 0041723 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a, 3	hrs	$	1,212	$ 63,275	$	1,212	$ 63,275	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		427	22,273		427	22,273	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 3	hrs		1,391	72,615		1,391	72,615	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				173,680		173,680	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	3,030	$ 158,162	$ 173,680	3,030	$ 331,842	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number PROVENA OUR LADY OF VICTORY # 0041723 Report Period Beginning: 01/01/04 Ending: 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 8,885,741	$	1
2	Cash-Patient Deposits	102,693		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	8,420,236		3
4	Supply Inventory (priced at)	588,898		4
5	Short-Term Investments			5
6	Prepaid Insurance	7,152		6
7	Other Prepaid Expenses	124,516		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 18,129,236	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	7,836,704		12
13	Land	6,851,272		13
14	Buildings, at Historical Cost	74,980,161		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	13,506,539		16
17	Accumulated Depreciation (book methods)	(40,776,212)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Goodwill	140,712		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 62,539,176	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 80,668,412	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,746,542	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,611,167		28
29	Short-Term Notes Payable	31,980		29
30	Accrued Salaries Payable	1,849,317		30
31	Accrued Taxes Payable (excluding real estate taxes)	44,053		31
32	Accrued Real Estate Taxes(Sch.IX-B)	240,643		32
33	Accrued Interest Payable	23,513		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Related Party	988,855		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,536,070	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,363,410		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	143,623		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,507,033	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 8,043,103	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 72,625,309	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 80,668,412	$	48

***(See instructions.)**

Facility Name & ID Number PROVENA OUR LADY OF VICTORY # 0041723 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 31,464,506	1
2	Restatements (describe):		2
3			3
4	**Adj. To Reconcile Consolidated Equity and Consolidated**		4
5	**Net Income to Nursing Facility Amounts**	1,019,718	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 32,484,224	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(465,241)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (465,241)	17
	B. Transfers (Itemize):		
18	**Transfer Debt to Provena Health**	40,606,326	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 40,606,326	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 72,625,309	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number PROVENA OUR LADY OF VICTORY # 0041723 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,788,348	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,788,348	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	364,669	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 364,669	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	153,619	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 153,619	23
	D. Non-Operating Revenue		
24	Contributions	38,064	24
25	Interest and Other Investment Income***	3,727	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 41,791	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Transportation	3,075	28
28a	Purchase Rebates	9,478	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 12,553	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,360,980	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	873,519	31
32	Health Care	2,102,938	32
33	General Administration	1,345,755	33
	B. Capital Expense		
34	Ownership	271,586	34
	C. Ancillary Expense		
35	Special Cost Centers	173,680	35
36	Provider Participation Fee	58,743	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,826,221	40
41	**Income before Income Taxes (line 30 minus line 40)****	(465,241)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (465,241)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number PROVENA OUR LADY OF VICTORY # 0041723 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,520	1,600	$ 44,687	$ 27.93	1
2	Assistant Director of Nursing	2,176	2,288	48,177	21.06	2
3	Registered Nurses	10,032	10,850	245,603	22.64	3
4	Licensed Practical Nurses	27,082	29,712	505,314	17.01	4
5	Nurse Aides & Orderlies	57,529	60,776	636,789	10.48	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,910	2,170	25,304	11.66	8
9	Activity Director	1,900	2,186	30,288	13.86	9
10	Activity Assistants	3,084	3,494	27,729	7.94	10
11	Social Service Workers	2,008	2,160	25,393	11.76	11
12	Dietician	1,880	2,160	37,555	17.39	12
13	Food Service Supervisor	1,995	2,251	22,161	9.84	13
14	Head Cook	6,907	7,303	55,243	7.56	14
15	Cook Helpers/Assistants	11,614	12,303	69,620	5.66	15
16	Dishwashers					16
17	Maintenance Workers	4,613	4,869	59,682	12.26	17
18	Housekeepers	14,608	15,826	115,164	7.28	18
19	Laundry	3,749	4,407	34,482	7.82	19
20	Administrator	1,792	1,920	68,239	35.54	20
21	Assistant Administrator	60	60	1,590	26.50	21
22	Other Administrative	4,165	4,496	67,052	14.91	22
23	Office Manager					23
24	Clerical	6,130	6,605	50,197	7.60	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Pastoral/Developm	2,956	3,200	44,123	13.79	33
34	TOTAL (lines 1 - 33)	167,710	180,636	$ 2,214,392 *	$ 12.26	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	260	$ 13,497	1,3	35
36	Medical Director	$500/mth	8,548	9,3	36
37	Medical Records Consultant	26	1,505	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	1	36	11,3	44
45	Social Service Consultant	8	456	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	295	$ 24,042		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	342	$ 14,059	10,3	50
51	Licensed Practical Nurses	694	26,415	10,3	51
52	Nurse Aides	1,443	32,172	10,3	52
53	TOTAL (lines 50 - 52)	2,479	$ 72,647		53

Facility Name & ID Number PROVENA OUR LADY OF VICTORY # 0041723 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Julie Cadle	Administrator	0	$ 52,222
Mark Fedyk	Administrator	0	17,607
Administrative Staff	Admissions	0	16,582
Administrative Staff	Education Services	0	16,967
Administrative Staff	Human Resource	0	33,503
Administrative Staff	Receptionist	0	50,197
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 187,078

B. Administrative - Other

Description	Amount
Corporate Service Fee	$ 77,184
Corporate IS Fee	53,316
Mgmt Fee	230,596
Mgmt Fee Interest	0
TOTAL (agree to Schedule V, line 17, col. 3)	$ 361,096
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Legal Expense	Various	$ 4,948
Wellspring/BKD Expense	Various	13,406
Collection Expense	Various	291
Employee Opinoin Survey	Various	1,053
Security System	Various	588
Shredding	Various	947
Transportation	Various	2,915
Medical Records	Various	8,199
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 32,347

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 44,058
Unemployment Compensation Insurance	16,685
FICA Taxes	157,794
Employee Health Insurance	199,498
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	13,527
Pension	84,523
Employee Recognition	1,597
Executive Benefits	3,843
Employment Screenings	11,921
Home Office Allocation	57,153
TOTAL (agree to Schedule V, line 22, col.8)	$ 590,599

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 93)	
Dues & Subscriptions	8,715
Advertising & Public Relations	18,325
Home Office Allocation	8,940
Less: Public Relations Expense	( )
Non-allowable advertising	(7,392)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 28,588

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 1,122
In-State Travel	6,648
See Schedule	
Home Office	3,157
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,927

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PROVENA OUR LADY OF VICTORY # 0041723 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number PROVENA OUR LADY OF VICTORY # 0041723 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **5048 - Life Services Network**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **Yes** If YES, what is the capacity? **107**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **23,616** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **58,743**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **KPMG** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **not issued yet**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.